Lessons From the Practice

The Steadfast Premise

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This afternoon we welcomed a new class of interns to our residency program. The department chair, the program director, and I offered a few words of advice. This annual event led me to reflect on the most memorable experience of my internship and how it continues to affect my advice today.

One Saturday, during the third month of my internship, I was called to the emergency department to admit a patient with acute leukemia. He had been well until a week before admission, when he presented to his primary care physician because of right knee pain. He and his wife had been hiking, and everyone agreed that the knee pain was related to overuse. It did not improve, however, and by the day of admission, severe fatigue, abdominal pain, and bloating had developed. His physician found splenomegaly, a painful, distended abdomen, and a high white blood cell count. The smear was consistent with acute leukemia, and he was transferred to our medical center for acute care.

The following morning, Sunday, he had a bone marrow aspiration to identify the type of leukemia and prepare for therapy. He was to begin chemotherapy on Monday morning. I noted with trepidation that his white blood cell count had risen to 56,000 per mm^3. Despite his present circumstances, the patient looked well, but he was a stoic man who offered few complaints. Remarkably, he and his wife were from my hometown, a small community where most folks know each other, and we had many things in common. Before going home, I had one more conversation with the patient and his wife about his condition. The last thing she said was how comforting it was to her that I was his physician. She spent that night at home, a two-hour drive away.

In preparation for rounds on Monday morning, I noted the white blood cell count to have risen to over 90,000 in the previous evening's blood specimen. When I entered the patient's room, he commented to me that his abdominal pain was worse. We started to discuss the chemotherapy when his face suddenly turned ashen. "I don't feel too good, Doc."

It was the look that every young clinician has heard about and dreads seeing for the first time, the look that indicates catastrophe and doom. I placed my hand on his shoulder and asked him to describe what was wrong. "I feel like I am about to die."

I took his blood pressure; he was in shock. I placed his head down. I took his pulse: 140 per minute. He was wide-eyed and scared, and so was I. I ran to the nursing station and asked them to call everyone for help immediately. I ran back to the patient's bedside, turned up his fluids, and began a quick, systematic evaluation. The main finding was a distended abdomen that was growing visibly more tense with each passing moment. "Help me!" All stoicism was gone.

The pharmacist, a man of considerable experience and compassion, appeared quietly in the room with a crash cart, awaiting my instructions. It seemed an eternity passed before my more experienced colleagues arrived. In the meantime, my patient gasped a parabolic "Oh," his eyes rolled back into his head, and he collapsed. A "Code Blue" was instituted, to no avail. We worked for 30 minutes to resuscitate him, and I remember a nurse yelling out that his white blood cell count was now 156,000.

The patient's wife was unreachable because, as we soon discovered, she was on her way to the hospital. Unfortunately, she entered the room shortly after the code was called, unaware that her husband had died. Her face bespoke the realization of what had just occurred, and all she could say was, "No, no, no, no, nooooo. . . ." She then turned to me, the trusted hometown colleague, and wailed, "Why? . . . What happened?"

I explained that something catastrophic had occurred, but that I was uncertain of the exact cause of death. I stood with her at the bedside and apologized profusely for his death, while she cried inconsolably. Thankfully, the staff members were much more accustomed to this sort of thing than I, and they guided her to a place to sit down.

I left the room, walked around the corner, went into a dark supply room, and let go of my own bottled emotions. Complete and utter devastation. This was my patient. I was the hometown hero. He wasn't supposed to die. I had failed. He should have had chemotherapy yesterday. I was crushed by the vision of his wife's face as she had entered the room.

The oncology nurse specialist, a wise woman, had noted my stony-faced departure from the room. Having seen more than a few interns experience such trauma, she followed me to the dark supply room, sat down, and quietly placed a comforting arm about my shoulders. We sat

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and grieved together, and she listened to me blame myself for the patient's death. I will never forget her kindness as she reassured me that there was nothing I could have done to save him. She was right, of course; the autopsy showed a ruptured spleen. I revealed the depth of my emotion to no one thereafter.

How does this memory affect my advice to each new group of interns? I advise them that long after the lectures, rounds, and conferences of residency are over, the recollections of patients and their families are most enduring. Internship is about developing clinical skills, and during this year we learn that patients are our greatest teachers. It is also a time for young physicians to learn their limitations, professional and personal, in the struggle with life and death. I advise the interns to be aware and supportive of each other and to seek counsel of trusted faculty and staff during times of crisis. Experiences such as mine leave indelible impressions on young clinicians, and sharing them with colleagues provides healing and learning.

Beyond curricular changes, insurance woes, and politics is the steadfast premise of our existence: as physicians, it is a privilege to care for people and, in return, to learn from them.

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"Lessons From the Practice" presents a personal experience of practicing physicians, residents, and medical students that made a lasting impression on the author. These pieces will speak to the art of medicine and to the primary goals of medical practice—to heal and to care for others. Physicians interested in contributing to the series are encouraged to submit their "lessons" to the series' editors.

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